



3.g.i Integration of Palliative Care into the PCMH Model

Project Objective: To increase access to palliative care programs in PCMHs.

Project Description: Per the Center to Advance Palliative care, “Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.” (<http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc>)

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Integrate Palliative Care into appropriate participating PCPs that have, or will have achieved NCQA PCMH certification.
2. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

- a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Palliative care helps to improve the quality of life of patients with a serious or life-threatening disease, with the goal of managing symptoms, side effects and related psychological, social, and spiritual



problems. Each hospital within our PPS offers palliative care services to support patients and families in learning to manage symptoms, relieve pain, plan medical treatment and improve quality of life.

The CNA reported that 47,464 Manhattan residents were hospitalized with at least one chronic disease that could benefit from palliative care services. The majority of these hospitalizations were for adults over 65 years old.

There are five facilities, 67 physicians, and three nurse practitioners in Queens that offer pain management services to the uninsured and Medicaid populations. There are also eight hospice programs and six organizations that offer additional palliative care services. In Brooklyn, there are 12 facilities offering pain management services to the uninsured and Medicaid populations and 23 organizations offering hospice services. In the Bronx, there are seven facilities offering pain management and 30 facilities providing hospice services. These facilities include nursing homes, health centers, and hospitals. While these resources are important, patients and families need more tools, particularly in the primary care setting, to support their chronic illness and resulting palliative care needs.

The CNA noted that the prevalence of chronic conditions that benefit from palliative services is higher than the availability of such services. Given the aging population, this disparity is likely to worsen. For example, by 2020, 11.7% and 13.6% of Queens and Manhattan residents respectively will be 65 or older. By 2030, those percentages increase to 14.5% and 16.1%. Given the aging of the population, this disparity will likely worsen as the prevalence of conditions suitable for palliative care increase with age.

Our PPS's approach to develop new or expand existing palliative care resources begins with increasing the availability of palliative care in the PPS service area by developing and deploying training and education for PCPs and staff on palliative care. Using evidence-based guidelines, the training will address: the importance of collecting advance directives and health care proxy data from patients; communication with patients around their palliative care needs (e.g., pain management); and, the transition from primary palliative care to specialty palliative care, including the establishment of referral criteria (see CNA need 1).

Our PPS will develop and implement an automated data collection and a tracking mechanism to follow palliative care initiatives across the PPS. The PPS will also work with Medicaid Managed Care (MMC) plans to identify issues related to coverage and provider networks, and develop written agreements with MMC plans on coverage and adequacy of palliative care services and networks, including hospice care.

- b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.



We expect to engage the following patient population: attributed patients, ages 18 and over, who are eligible for a primary palliative care intervention. The PPS has defined eligibility based on a series of ICD-9 codes associated with chronic diseases that could benefit from palliative care services (e.g., metastatic solid tumor cancers, advanced depression, COPD, generalized pain, stroke). In addition to having one of these diagnoses, the patient population will meet one at least one of the following utilization criteria: one hospitalization in a year, one ED visit in a year, and/or 3 or more outpatient visits in three months or 12 or more outpatient visits in 12 months (see CNA need 1).

- c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Our PPS has a range of assets and resources to help achieve the goals of this DSRIP project. There are palliative care teams in each of our PPS's 12 hospitals. Their expertise has informed the development of our approach and will continue to support its implementation, in particular by evaluating existing curricula and developing trainings for health care providers and their staff. Our PPS has 26 providers who are board-certified in palliative care or who have certifications pending. Outpatient palliative care services are provided at the following PCMH-recognized clinics in our service area: Bellevue, Metropolitan, Kings, Lincoln. In addition, University Hospital of Brooklyn has a palliative care clinic which provides services one session per week. Coney Island Hospital has a 19-bed Pain and Symptom Control Palliative Care Unit which can offer lessons learned around care coordination for patients receiving palliative care services.

Our PPS also has resources to support the development of a palliative care curriculum and training for providers and other members of the care team. This includes the expertise of SUNY Downstate Medical Center which has the capability to establish a fellowship program for physicians and certificate programs to train physicians, nurse practitioners, nurses, social workers, and other allied health professionals. In addition, there are palliative care organizations currently developing curricula for generalist palliative care that may provide a foundation for the education and training component of this intervention.

We also intend to leverage the capacity and expertise of our partners, with whom we have well-established relationships. This includes hospices operated by HHC's skilled nursing facility, Metropolitan Jewish Hospice and Homecare, Visiting Nurse Service of New York (VNSNY), Cavalry, and Rosary Hill. Rosary Hill is particularly valuable in that they provide inpatient end of life care for the undocumented. We will also work closely with VNSNY and their Compassionate Care Program.

HHC operates a Palliative Care Council that serves as a forum to facilitate the introduction of the principles and practice of palliative medicine and to advance the field of palliative care through innovation, education and research. For the purposes of this project, the Council can focus on integrating palliative care into PCMH clinical practice and could be used as a forum to address palliative care for all PPSs in our service area. HHC also has "PallTrack" which provides data on



inpatient referrals within the HHC system. Combined, these resources have helped to inform the design of this intervention, and will continue to be of value during implementation planning.

- d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

We have identified a number of challenges or anticipated issues that we intend to address. First, PCPs and their staff may be challenged to incorporate palliative care into their everyday clinical practice. This is due to sometimes short patient visits, workflow changes and data collection (e.g., advanced care directives), managing care transitions, and the need to establish new referral patterns. Our PPS will alleviate this burden by providing standardized training and materials to both providers and other members of the care team, as well as making available an enterprise-wide care management platform. In addition, we will explore the possibility of hiring specially trained physician extenders to support patients' palliative care needs.

Our PPS has also identified potential capacity issues vis-a-vis the availability of specialty palliative care. To address this, we will analyze capacity issues and develop a plan to bridge the gaps.

Finally, we anticipate challenges in managing handoffs between primary palliative care and specialty palliative care. Our PPS will determine the optimal processes for partners to track referrals made to palliative care from the inpatient or outpatient/community setting. In addition, providing training to members of the care team regarding handoffs will be crucial.

- e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

We intend to work with all PPSs in NYC that have selected this intervention in order to coordinate approaches. As part of planning activities to date, our PPS has collaborated with Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and beginning identifying areas for collaboration during implementation and operations.

Through implementation planning, we expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; development of workforce strategy, including common job descriptions and functional capabilities; workforce training efforts; data sharing; and selection of culturally competent patient education resources.

Post application, we intend to broaden our collaboration efforts to include other PPSs in our service area that have selected this project. We believe this coordination will be crucial to reduce the burden on



providers and CBOs, addressing key capacity and workforce needs, improving clinical outcomes and patient experience.

HHC will also make available the Palliative Care Council as a forum for cross-PPS coordination within NYC. This would enable palliative care teams from all PPSs to leverage the expertise of the Council and also to have a forum to coordinate and collaborate with peers to support the development of common materials and approaches.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? *(Please mark the appropriate box below)*

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in



during the life of the DSRIP program related to this project's objective?

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.



The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care beyond the focus areas supported by the H-MH program, such as training around palliative care.

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Project Plan Application
